STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155066	A. BUILDING 00 B. WING	07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER WOODS	1809 N MADISON AVE ANDERSON, IN46011

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 18, 19, 20, and 21, 2011 Facility number: 000026 Provider number: 155066 AIM number: 100274820 Survey team: Donna M. Smith, RN, TC Tammy Alley, RN Toni Maley, BSW Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 15 Medicaid: 47 Other: 5 Total: 67 Sample: 15 Supplemental sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 7/27/11 by Suzanne Williams, RN	F0000	F0000	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0221 SS=E	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to ensure residents who resided on the Life Paths Unit (Unit for residents with developmental disabilities) were not restricted to the unit without a restraint assessment and/or medical justification for the use of a locked door restraint for 2 of 4 residents reviewed for restraint use in a sample of 15 (Residents #42 & #46) and 5 of 5 residents reviewed for restraint use in a supplemental sample of 6 (Residents #52, #51, #48, #38 & # 37). This deficient practice had the potential to impact 15 of the 23 residents who resided on the Life Path unit and were able to independently ambulate or propel their own wheelchair. Finding include: During a 7/18/11, 9:00 a.m. initial observation of the facility, the facility had three units, Moving Forward, Golden Orchards and Life Paths. The Life Paths unit (a specialized unit for developmental disability) was separated from the rest of the facility by a locked door which required a key pad code. The front half of the facility, which was outside of the	F0221	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does ensure that residents have the right to be free from any physical restraints that are not required to treat the resident's medical symptoms. **Corrective action accomplished for those residents found to have been affected:** The magnetic lock and keypad system for the Life Path Center doors was disconnected on July 20, 2011. Resident #52, #42, #46, #51, #48, #38 and #37 were informed of the removal of the magnetic lock. **How the facility identified other residents having the potential to be affected:** All residents residing on the unit have the potential to be affected. The magnetic lock and keypad system for the Life Path Center doors was disconnected on July 20, 2011 for all residents residing on Life Path Center. Residents residing on Life Path Center were re-assessed for risk of elopement. **Systemic Changes the facility made:** The	08/20/2011

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	secured Life Paths unit, included but was not limited to, a large television area with overstuffed chairs; a small lounge with a snack machine and soft drink machine; the business office where resident funds accounts were accessed; two units of resident rooms; the kitchen; an activity room and a large dining room. During a 7/18/11, 9:25 a.m., interview, LPN #2, who was the day charge nurse on the Life Paths unit, indicated the Life Paths unit was a secured unit with a locked door. He indicated residents could not leave the Life Path unit without staff assistance. During a 7/18/11, 9:40 a.m., interview, the Administrator indicated the Life Path unit had a locked door to maximize the benefits of the specialized unit and offer safety. During a 7/18/11, 3:55 p.m., interview, the Social Services Director indicated there was not an assessment regarding the secured locked door for each resident who lived on the Life Paths unit. The residents have to be supervised to leave the unit, and a staff member must enter the code in order to unlock the door. Review of a current, undated, facility document titled "Residents that can		magnetic lock and keypad system for the Life Path Center doors was disconnected on July 20, 2011. Facility staff members, residents, resident's responsible parties and resident's physicians were advised that the magnetic lock and keypad system for the Life Path Center doors was disconnected. Physician's orders for the secured unit were discontinued. Residents residing on Life Path Center were re-assessed for risk of elopement. Elopement risk assessments will be completed upon admission, change of condition and at least quarterly on all residents who reside on the unit. How the corrective action will be monitored: The Life Path Center Director and Maintenance Supervisor will monitor the doors in accordance with the facility's decision to disconnect the magnetic lock and keypad system on July 20, 2011. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or	

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	independently ambulate or propel self in wheelchair" which was provided by the Administrator on 7/19/11 at 10:00 a.m. indicated 15 of the 23 residents, who resided on the Life Path unit were able to self ambulate or self propel their wheelchair. Residents #52, #42, #46, #51, #48, #38 and #37 were on this list. During a 7/19/11, 11:00 p.m., interview, the Administrator was queried as to how the locked doors of the Life Path unit assisted in maximizing programing or assisted in the treatment of developmental disabilities and if the resident who resided on the unit had been assessed for the need for a locked environment. During a 7/19/11, 12:30 p.m., interview, the Administrator indicated the facility administration had not considered the locked doors to the unit as a restraining device. The goal had been to create a small structured environment. The facility had not considered the option of closing the door as apposed to locking it in order to create a smaller purposefully designed unit. The facility had not assessed the residents for the need for a secured/locked unit to treat a medical symptom or condition. 1.) Resident #52's record was reviewed on 7/20/22 at 10:15 a.m.		action. How often and for how long will this plan of correction be monitored? This plan of correction will be monitored at least quarterly for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. Will monitoring occur on all shifts? Monitoring of this plan of correction will occur on day and evening shifts. **By what date the systemic changes will be completed:** August 20, 2011	

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Resident #52's current diagnoses included, but were not limited to, Huntington's chorea, speech disorder, and dysphasia.

Resident #52 had a current, 4/27/11, annual, Minimum Data Set Assessment, which indicated understood others, was sometimes understood by others, ambulated independently, felt it was very important to visit with family and friends and enjoyed going outdoors. Resident #52 had memory impairment and need assistance for decision making.

During a 7/18/11, 9:40 a.m., interview, LPN #2 indicated Resident #52 had a family member who resided in the facility on another unit, and the resident greatly enjoyed visiting his family member.

Resident #52's record lacked:
a.) an assessment for the use of a locked unit door restraint;

b.) an identified medical symptom or condition which required the use of a locked door restraint;

c.) a consent for the use of a locked door restraint.

d.) any documentation which indicated a secured/locked unit improved or enhanced

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	the resident's quality of life. During the following observations, Resident #52 was observed walking on the Life Path unit: 7/18/11, 12:00 p.m. 7/18/11, 5:10 p.m. 7/19/11, 8:10 a.m. 7/20/11, 7:50 a.m. During a 7/18/11, 2:00 p.m. interview, LPN #2 indicated Resident #52 would ask to leave the unit to see his family member. 2.) Resident #42's record was reviewed on 7/18/11 at 11:00 a.m. Resident #42's current diagnoses included, but were not limited to, history of head injury, mental retardation and hypertension. Resident #42 had a current 4/21/11, quarterly, Minimum Data Set Assessment, which indicated he understood others and was understood by others, used a walker and had no significant disruptive behaviors. Resident #42 had a 9/13/10 "OBRA Annual Resident Review Case Analysis" (assessment for individuals with developmental disabilities) which recommended activities for socialization.			

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Resident #42's record lacked:
a.) an assessment for the use of a locked unit door restraint;

b.) an identified medical symptom or condition which required the use of a locked door restraint;

c.) a consent for the use of a locked door restraint.

d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life.

During a 7/18/11, 10:30 a.m., observation, Resident #42 moved his wheelchair a very short distance.

3.) Resident #46's record was reviewed on 7/18/11 at 10:50 a.m.

Resident #46's current diagnoses included, but were not limited to, mental retardation, speech disorder, and depression.

Resident #46 had a current,7/4/11, quarterly, Minimum Data Set Assessment, which indicated the resident sometimes understood others and was sometimes understood by others, used a wheelchair for mobility, did not wander, and enjoyed

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	going outside. Resident #46 had a current 3/22/10 "OBRA Annual Resident Review Case Analysis" which indicated the resident needed to participate in social and recreational activities to encourage social stimulation. Resident #46's record lacked: a.) an assessment for the use of a locked unit door restraint. b.) an identified medical symptom or condition which required the use of a locked door restraint; c.) a consent for the use of a locked door restraint. d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life. 4.) Resident #51's record was reviewed on 7/20/11 at 10:00 a.m. Resident #51's current diagnoses included, but were not limited to, depression, mental retardation and speech disorder. Resident #51 had a current 5/4/11, quarterly, Minimum Data Set Assessment, which indicated understood others and			

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	was understood by others, used a wheelchair, and had no disruptive behaviors. Resident #51's record lacked: a.) an assessment for the use of a locked unit door restraint; b.) an identified medical symptom or condition which required the use of a locked door restraint; c.) a consent for the use of a locked door restraint. d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life. During observations on 7/18/11 at 9:45 a.m., 11:35 a.m., 5:15 p.m. and 7/19/11 at 9:10 a.m. Resident #51 was observed propelling her wheelchair throughout the Life Paths unit. Following the Life Path Unit being unlocked on 7/21/11 at 9:25 a.m., Resident #51 was observed at the business office chatting with facility staff and laughing. 5.) Resident #48's record was reviewed on 7/20/11 at 9:45 a.m. Resident #48's current diagnoses included, but were not limited to,mental retardation,			

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	anxiety, and hypertension. Resident #48 had a current 5/5/11, quarterly, Minimum Data Set Assessment, which indicated the resident understood others and was understood by others, used a wheelchair for mobility and did not display disruptive behaviors. Resident #48 had a current, 11/11/10, care plan problem regarding the need to increase activity participation. An approach to this problem was to provide activities in areas in which the resident prefers such as front lounge and outside (both located off unit). Resident #48's record lacked: a.) an assessment for the use of a locked unit door restraint; b.) an identified medical symptom or condition which required the use of a locked door restraint; c.) a consent for the use of a locked door restraint. d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life. During observations on 7/18/11 at 11:45 a.m. and 5:15 p.m., Resident #48			

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	propelled her wheelchair in the hallway of the Life Paths unit. 6.) Resident #38's record was reviewed on 7/20/11 at 9:30 a.m. Resident #38's current diagnoses included, but were not limited to, mild mental retardation and cerebral palsy. Resident #38 had a current 7/4/11, quarterly, Minimum Data Set Assessment, which indicated the resident understood others and was understood by others and used a wheelchair for mobility. Resident #38's record lacked: a.) an assessment for the use of a locked unit door restraint; b.) an identified medical symptom or condition which required the use of a locked door restraint; c.) a consent for the use of a locked door restraint. d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life. 7.) Resident #37's record was reviewed on 7/20/11 at 9:15 a.m.			

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	Resident #37's current diagnoses included, but were not limited to, mental retardation, mental retardation, and depression. Resident #37 had a current 5/18/11, quarterly, Minimum Data Set Assessment, which indicated sometimes understood others and was sometimes understood by others and used a wheelchair for mobility.. Resident #37's record lacked: a.) an assessment for the use of a locked unit door restraint; b.) an identified medical symptom or condition which required the use of a locked door restraint; c.) a consent for the use of a locked door restraint. d.) any documentation which indicated a secured/locked unit improved or enhanced the resident's quality of life. 8.) Review of a current, 3/10, policy titled "Physical Restraints" which was provided by the administrator on 7/21/11 at 8:35 a.m. indicated the following: "Restraint use will be considered only after less restrictive measures have failed,			

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	and the interdisciplinary team determines that they are needed to treat resident (s) medical symptoms." "Definition: A physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement..." " A physical restraint assessment will be completed prior to the initiation of a restraint." Review of an undated, untitled document provided by the Administrator in 7/19/11 at 10:55 a.m. indicated the Life Paths unit had been a secured, locked unit from 5/23/11 until the present date. 3.1-26(a) 3.1-26(g) 3.1-26(o)			
F0254 SS=C	The facility must provide clean bed and bath linens that are in good condition. Based on observations, interviews, and record review, the facility failed to ensure linen was available and in good condition for residents' care for 3 of 3 hallways observed for 3 of 5 days observed. This deficiency affected 2 of 4 residents individually interviewed (Resident #25	F0254	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does provide clean	08/20/2011

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	and #57) and 2 of 2 residents in the group meeting (Resident #B and #C), and had the potential to impact 67 of 67 residents residing in the facility. Findings include: 1. On 7/18/11 from 11:05 a.m. to 11:40 a.m., Resident #61's transfer and personal care was observed. One towel was observed to be dull in color with gray to dark gray stained areas observed throughout the towel. Also, no washcloths use was observed as CNA #4 completed the resident's personal care with one side of the towel for cleansing and rinsing, and the other side was used to dry the resident during her personal care. At this same time during an interview, CNA #4 indicated she had trouble obtaining linen all of the time and had to work without washcloths and towels. 2. On 7/18/11 at 10:55 a.m. during an interview, Resident #57 indicated 2 to 3 times a week the facility did not have enough washcloths and towels for care. She also indicated the linen had been scratchy and "rough as a cob." 3. On 7/19/11 from 8:10 a.m. to 8:40 a.m., the following was observed on the hallway linen carts:		bed and bath linens that are in good condition. **Corrective action accomplished for those residents found to have been affected:** On July 19, 2011, GFS technician inspected all washing machine formulas for appearance, chlorine residual and pH of linens (brightness and softness) and made any necessary adjustments. Regarding residents # 25, #57, #B and #C, the facility completed an inventory of facility linens. Any linen identified as discolored were pulled from service, pre-soaked, laundered again and either put back into service or discarded. Any frayed or torn linens identified were discarded. Discarded linens were replaced with new linens. Hallway linen closets and carts were inspected, linens counted and replenished to meet the needs of residents. **How the facility identified other residents having the potential to be affected:** Per the 2567, it states all residents had the potential to be affected, thus corrective actions and systematic changes apply to all residents. **Systemic Changes the facility made:** Laundry staff shift times were re-evaluated and adjustments made. On 7/20/11, Regional Director of Laundry and Housekeeping re-inserviced laundry staff with on checking washing machine chemical product supply, chemical supply	

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	On the Moving Forward hallway with LPN #7: 15 gowns, 1 flat sheet, 12 pillowcases, 2 incontinent pads, and 6 fitted sheets. One of the fitted sheet was observed with a saucer size yellow stain; several pieces were dingy in color; On the Golden Orchard hallway with LPN #7: 9 incontinent pads, 7 washcloths, 11 pillowcases, 3 fitted sheets, 2 flat sheets, 8 gowns, and 34 towels. At least 4 of these towels were very dingy in color, and 1 towel was observed with frayed edges all around the towel; On the Life Path hallway with the Housekeeping Supervisor: 5 incontinent pads, 5 flat sheets, 21 pillowcases, 8 gowns, and 12 fitted sheets. One of these fitted sheets was observed with a quarter size brown stain on it. At this same time during an interview, the Housekeeping Supervisor indicated the stained fitted sheet should not have been placed on this linen cart. She also indicated she had 2 different shifts for the laundry room, which were 8 a.m. to 2:30 p.m. and from 3:00 p.m. to 8:30 p.m., and staff were able to get the laundry done. She also indicated she had backup washcloths in her office and had recently put more washcloths out. Then, in this same hallway she was observed to obtain a key from the shower room door and explained		lines, linen sorting and loading and proper washer program selection. Laundry staff will observe linens daily while sorting and folding linens for discolor or fraying. Any linen found to be discolored will be pulled out of service and further inspected by the Laundry Supervisor/designee for additional laundering or discarded. Frayed or torn linens will be pulled out of service and discarded. Inventory of linen par levels will continue to be conducted at least monthly by Laundry Supervisor/designee and new linens ordered as needed. On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator in-serviced nursing department staff with post-test regarding immediate notification of the charge nurse or ED/designee if additional linens are needed. How the corrective action will be monitored: How often and for how long will this plan of correction be monitored? A quality and quantity CQI audit will be conducted daily (5 days per week) for two weeks and monthly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. Administrator/designee will	

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	she kept a "back up" linen cart locked up in this hallway. She indicated this same key was accessible to all staff, who should be aware of this linen cart. This "back up" cart was observed with sufficient supply of all linen. Twenty-eight washcloths were counted on this cart with 4 of these 28 observed dingy in color also. Again, during an interview at this same time, the Housekeeping Supervisor indicated she had noticed the dingy laundry and had cooperate personnel coming in today to check on the problem. At this same time and during an interview, the Housekeeping Supervisor was shown the frayed towel on Golden Orchard hallway linen cart. She indicated the towel should not have been put on the hallway linen cart and was removed by the Housekeeping Supervisor at this time. 4. On 7/19/11 from 9:10 a.m. to 9:50 a.m., Resident #61's personal care was observed. During this care observation, 3 towels were used for her care as CNA #11 informed CNA #12 they were out of washcloths. At this same time during an interview, both Cans indicated they were unaware of another linen cart other than the one down the opposite hallway. CNA #11 indicated one would have to contact the Housekeeping supervisor for more laundry. At this same time during an interview, LPN #7 also present in the		conduct audits and will monitor for compliance. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. Will monitoring occur on all shifts? Monitoring will occur on all shifts. **By what date the systemic changes will be completed:** August 20, 2011	

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room indicated she was unaware of any other area to obtain linen besides the linen cart down the opposite hallway. She indicated the Housekeeping supervisor should be notified concerning the linen.

5. On 7/19/11 from 1:15 p.m. to 2:50 p.m., the environmental tour was conducted. In the laundry room during an interview, Laundry aide #15 indicated if a piece of linen was stained, she indicated the linen would not be for resident's use. At this same time, the Cooperate repairman indicated the corrections he had made today had improved the laundry, for example, made it softer and cleaner.

The "SERVICE REPORT," dated 7/19/11, was provided by the Administrator on 7/20/11 at 8:25 a.m. This service report indicated an emergency call was made to the facility. The linen was indicated as "coming out a bit dingy and rough" with all chemicals pumping correctly.

6. During a 7/9/11, 9:30 a.m., confidential group interview with 2 residents (#B & C) who were identified as interviewable by the Administrator on 7/18/11 at 10:55 a.m., the following concerns regarding washcloths and towels were made:

a.) 2 to 3 times a week they use a towel as a washcloth because they are out of

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	washcloths. b.) The washcloths and towels are often stained and frayed. They are so stained you do not want to use them. c.) In the recent past there was a problem with the linen smelling like it had not been properly cleaned. 7. During an interview with Resident # 25 on 7/20/11 at 10:15 a.m., she indicated there are not enough wash clothes to provide her care. She indicated at least 2-3 times a week she was washed with towels only. 8. A July 2008 policy titled "Handling Clean Linen" was provided by the Administrator on 7/20/11 at 8:25 a.m., and deemed as current. The"Handling Clean Linen" policy indicated: "Objective To provide clean, fresh linen to each resident...An adequate supply of clean linen must be available at all times...." 3.1-19(g)(4) 3.1-19(g)(5)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observations, record reviews, and interviews, the facility failed to	F0282	The filing of this plan of correction does not constitute an admission that the alleged	08/20/2011

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	ensure the physician's orders were followed concerning an abductor pillow for 1 of 1 resident with an abductor pillow (Resident #61), for the application of bunny boots for 1 of 2 residents observed (Resident #61), for the daily administration of all medications for 1 of 9 residents reviewed (Resident #61), and for the correct amount of sliding scale insulin coverage for 1 of 1 resident (Resident #57) in a sample of 15. Findings include: 1. Resident #61's record was reviewed on 7/18/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to, open reduction internal fixation of the right hip, dementia, anemia, and debility. The physician order, dated 7/13/11, was abductor pillow when in bed and in her wheelchair. The physician order, dated 7/18/11, was bunny boots on at all times except for activities of daily living care. The physician order, dated 7/01/11, was Plavix (coronary artery disease) 75 milligrams (mg) give 1 tablet daily and Seroquel (dementia) 50 mg take 1 two times a day. The "MEDICATION ADMINISTRATION RECORD" for 7/2011 indicated the resident's medication, Plavix, was unavailable for administration on 7/01 to 7/04, inclusive and the medication, Seroquel, was unavailable for administration on 7/04 at 8:00 p.m. On 7/18/11 from 11:05 a.m. to 11:40 a.m., Resident #61's transfer and personal care was observed. After the resident was transferred to her bed, CNA #4 removed the resident's abductor		deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does provide services by qualified person/care plan. **Corrective action accomplished for those residents found to have been affected** Regarding resident #61, a medication error was completed regarding the Plavix and Seroquel. The medication was available. The attending physician was notified. CNA #4 and #5 were immediately re-inserviced on the abductor placement. CNA #11 and #12 were re-inserviced on the use of booties and utilizing the CNA assignment sheet. Regarding resident #57, Medication error report regarding the sliding scale insulin was completed and the attending physician was notified. There was no negative outcome. **How the facility identified other residents having the potential to be affected:** The customer care team made resident rounds for placement of assistive devices any issues identified were immediately addressed. A sliding scale insulin audit was completed on all residents receiving sliding scale insulin for the last 30 days and any issues identified were addressed. **Systemic Changes the facility made:** On 8/2/11, 8/5/11, 8/8/11	

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	pillow between the resident's legs. The resident was then observed to be transferred from side to side without the abductor pillow by CNA #4 and CNA #5 as her personal care was performed. These tasks included the removal of the soiled brief, completion of her personal care, and redressing with a new brief. After the resident's care was completed, the abductor pillow was repositioned between her legs. On 7/19/11 at 8:40 a.m. during an interview, Physical Therapy #9 indicated the abductor pillow should be kept in place, which was between the resident's legs, to keep the resident from crossing her feet/legs while she was being turned. On 7/19/11 at 9:05 a.m. during an interview, the Director of Nursing indicated the CNAs were orientated during their orientation concerning an abductor pillow as it was on their orientation check off list where they were to read the information and then, would sign off on it. She indicated no separate inservice was held concerning Resident #61's abductor pillow. The "ABDUCTION PILLOW" validation skill was provided by the Nursing Consultant on 7/19/11 at 10:00 a.m. The information included how the abductor pillow should be applied with no information concerning when it should be used. On 7/19/11 at 9:50 a.m. after Resident #61's personal care was completed by CNA #11 and CNA #12, the resident remained in her bed to rest without her booties on. Her booties were observed in a chair in her room. On 7/20/11 at 10:20 a.m. and at 3:45 p.m., Resident #61 was observed in her bed without her booties on. At this same time her booties were		and 8/12/11, Staff Development Coordinator inserviced nursing staff with post-test on placement of assistive devices, use of abductor pillows and utilizing CNA assignment worksheets. All residents with new orders/change in condition will be discussed in the clinical meeting immediately following morning meeting. Care plan interventions will be reviewed and updated at that time. CNA assignment sheets will be updated to reflect changes made to the resident's care plan during the meeting. All new nursing employees will be trained on CNA assignment sheets and assistive devices during orientation. In the event that medication is not available the nurse will attempt to locate the medication. Check the EDK for the medication; contact the pharmacy for stat delivery. The physician will be notified if needed and the DNS/designee will be contacted as needed. On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator re-inserviced licensed nurses with post-test on insulin administration and documentation via sliding scale. How the corrective action will be monitored: How often and for how long will this plan of correction be monitored?	

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	observed in her chair in her room. On 7/21/11 at 9:45 a.m. during an interview, LPN #13 indicated Resident #61's booties were being used as a skin preventive measure. On 7/21/11 at 9:50 a.m. during an interview, the Director of Nursing (DON) indicated a new physician order, for example, Resident #61's booties, was reviewed in the daily meetings and then, placed on the CNA assignment sheets and the care plan. At this same time during an interview, the DON indicated the resident's Plavix and Seroquel medication had been delivered on 7/01/11 and was available to be given as the medications were in the medication drawer. 2. Resident #57's record was reviewed on 7/18/11 at 5:20 p.m. The resident's diagnoses included, but were not limited to, diabetic mellitus. The physician's order, dated and signed 7/13/11, was Novolog insulin sliding scale 4 times daily. Insulin coverage was 100 - 124 = 1 unit (u); 125 - 149 = 2 u; 150 - 174 = 3 u; 175 - 199 = 4 u; 200 - 224 = 6 u; 225 - 249 = 7 u; 250 - 274 = 9 u; 275 - 299 = 10 u; 300 - 324 = 12 u; 325 -349 = 14 u; 350 - 374 = 15 u; and 375 - 399 = 17 u. The "Capillary Blood Glucose Monitoring Tool" for 7/2011 indicated the following: On 7/06 at 5:00 p.m., the blood sugar (BS) was 127 with 1 u of insulin coverage given (2 u for BS of 125 - 149); On 7/10 at 9:00 p.m., the BS was 324 with 14 u of insulin coverage given (300 to 324 u = 12 u); On 7/17 at 5:00 p.m., the BS was 189 with 3 u of insulin coverage given (175 - 199 = 4 u).		This plan of correction will be monitored for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. The charge nurses will monitor for placement of assistive devices by use of the MARS and TARS during their daily rounds. Any issues identified will be addressed. A resident rounds CQI audit will be completed for assistive devices at least daily (5 days per week) for two weeks, weekly for four weeks and then as determined by members of the IDT team. The DNS/designee will be responsible for coordination of the monitoring. Facility will complete an audit at least quarterly to review carts for availability of medications. Pharmacy will complete a quality assurance visit to review carts for availability of medications. Discrepancies will be reported to the DNS. The DNS will be responsible to monitor. A sliding scale insulin audit will be completed at least weekly and staff will be re-inserviced as	

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	On 7/21/11 at 9:50 a.m. during an interview, information was requested for the 7/06 at 5:00 p.m., the 7/10 at 9:00 p.m., and the 7/17 at 5:00 p.m. insulin coverage. On 7/21/11 at 12:55 p.m. during an interview, the Director of Nursing indicated she had no further information concerning the sliding scale insulin. 3.1-35(g)(2)		needed. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. Will monitoring occur on all shifts? Monitoring will occur on all shifts. **By what date the systemic changes will be completed:** August 20, 2011	
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review, observation, and interview, the facility failed to ensure anchored catheter care and perineal care was provided in a manner to prevent the possibility of infection for 1 of 1 resident observed with an anchored catheter (Resident # 25) and for 1 of 2 perineal care observations (Resident # 61) in a sample of 15.	F0315	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does ensure that a resident who enters the facility without an indwelling catheter is not	08/20/2011

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Findings include:

1. The record for Resident # 25 was reviewed on 7/19/11 at 8:20 a.m.

Current physician orders for July 2011 indicated the resident had an anchored catheter.

A physician order dated 6/21/11 indicated an order for a urinalysis with culture and sensitivity.

A urine culture dated 6/24/11 indicated the resident had greater than 100,000 gram negative rods, indicating a urinary tract infection.

A physician order dated 6/24/11 indicated an order for nitrofurantoin 100 milligrams (antibiotic) to be given twice daily for 7 days.

During a transfer observation of Resident # 25 on 7/18/11 at 11:15 a.m., CNA # 25 removed the anchored catheter bag and tubing from the dignity bag and placed it on the floor under the resident's wheelchair. The anchored catheter bag and tubing was full of yellow urine. CNA # 25 picked up the drainage bag and handed it to CNA # 4. The drainage bag was held at a level above the bladder. At

catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. A resident who is incontinent of bladder does receive appropriate treatment and services prevent UTI.
Corrective action accomplished for those residents found to have been affected Regarding Resident #25, as stated in the 2567, the ADNS intervened and instructed the CNAs to lower the drainage bag below the bladder. Regarding Resident #61, all nursing staff was re-educated on pericare. **How the facility identified other residents having the potential to be affected:** A catheter assessment was completed on all residents with catheters. Any resident who is incontinent of urine has the potential to be affected. **Systemic Changes the facility made:** On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator presented an inservice to the nursing staff with post-test and return-demonstration regarding foley catheter care and positioning, use of washcloths during pericare and completing pericare from front-to-back on females. All nursing staff had skills validations completed on pericare and transfers of residents with anchored catheters. DNS/designee will

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	that time, the Assistant Director of Nursing arrived in the room and informed the CNAs to lower the drainage bag below the level of the bladder.		make rounds throughout the facility to ensure pericare and catheter care is provided appropriately. How the corrective action will be monitored: Skills validations will continue to be completed on pericare and transfers of residents with anchored catheters. How often and for how long will this plan of correction be monitored? A catheter CQI will be completed daily for five days, then weekly times four weeks and quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. Will the DNS/Designee make these rounds on all shifts? The DNS/Designee will make rounds on all shifts.	

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			Will monitoring occur on all shifts? Monitoring will occur on all shifts. **By what date the systemic changes will be completed:** August 20, 2011	

2. Resident #61's record was reviewed on 7/18/11 at 2:20 p.m. The resident's diagnoses included, but were not limited to, Stage 3 renal failure.

The "History & Physical," dated 6/21/11, indicated the resident's past medical history included, but was not limited to, history of chronic recurrent urinary tract infection.

On 7/18/11 from 11:05 a.m. to 11:40 a.m., Resident #61's transfer and personal care was observed. CNA #4 indicated the resident had been incontinent of urine. Next, she was observed to cleanse with the same area of the cloth in the same sweeping motion across the lower abdomen, up and down the right groin, across the abdomen, and up and down the left groin, and then, up and down the middle followed by rinsing the personal area in the same manner. After the resident was patted dry, her rectal care was completed, and the resident was redressed.

3. The "Peri-Care" policy was provided

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	by the Administrator on 7/20/11 at 8:25 a.m. This current policy indicated the following: "A. Purpose 1. To cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image ...C. Procedure ...16. Female: Using peri care product and wet wash cloth, wash labia first. Always wash from front to back. Be sure to spread the labia and cleanse thoroughly. Rinse and dry completely....." 3.1-41(a)(2)			
F0319 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. Based on observations, record review, and interview, the facility failed to ensure a resident with adjustment difficulty resulting in anxiety was assessed and evaluated to maintain/improve the resident's adjustment to the facility for 1 of 2 recently admitted residents reviewed	F0319	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care.	08/20/2011

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	in a sample of 15. (Resident #59) Findings include: 1. Resident #59's record was reviewed on 7/18/11 at 4:40 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 7/02/11. The undated "Social History & Psychosocial Assessment" indicated the resident was admitted on 7/02/11. The "Cognitive/Emotional Status/How does the resident cope?" indicated the resident was confused and anxious. The "Event(s) Leading to Placement and Reason(s) for Admission" was indicated as increased confusion. The "Mood or behaviors noted" was indicated as the resident was anxious. The "Resident Progress Notes" indicated the following: On 7/02/11 at 4:00 p.m., the resident was admitted to the facility. He was indicated as alert and confused, moderately anxious at times, and was forgetful. On 7/03/11 at 1:40 a.m., the resident was very confused and unable to remember any explanations of why he was here for so long.		The facility does ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services. **Corrective action accomplished for those residents found to have been affected** Regarding Resident #59, the physician was contacted and an order was received for a psychiatric evaluation and treatment for the resident. Social Services assisted resident with adjustment issues. **How the facility identified other residents having the potential to be affected:** All newly admitted residents will be reviewed for difficulties in adjustment. Any issues identified will be communicated to the attending physician. **Systemic Changes the facility made:** On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Social Services provided an in-service for all staff members with post-test on behavior management. Any residents identified with symptoms of difficulty adjusting, staff will complete a behavior form and communicate to the charge nurse and social services. A care plan will be developed with interventions to address the behavior. This will be communicated to the staff via the CNA assignment sheet and care plan. Any new or worsening behaviors will be reviewed by the IDT and care plan will be revised	

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	On 7/04/11 at 11:21 a.m., the resident was restless and agitated. He was continuously asking to go home and leave. The resident stated he was left here and was being held. The resident was redirected numerous times, which were unsuccessful, and required medication to calm the resident down. On 7/04/11 at 3:15 a.m., the resident was noted to have been given frequent reassurances, which help some but were quickly forgotten. On 7/05/11 at 11:40 p.m., the resident was indicated as alert but very confused, and "anxious at times," with medication given at 6:00 p.m. "with some relief." On 7/10/11 at 2:15 p.m., the resident was sitting in the hallway looking around and interacting with staff with no further complaints. He was medicated for anxiety. On 7/12/11 at 3:06 a.m., the resident was confused most of the time but alert to self. On 7/12/11 at 7:30 p.m., the resident was very forgetful and became anxious at times. On 7/15/11 at 7:52 p.m., the resident was alert to self, disorientated to time and place, and stated "why do you hold people in here like a jail?" On 7/17/11 at 3:47 a.m., the resident was indicated as suffering from Alzheimer's and did not understand why he was her and why he could not go home.		as indicated. Social Services will work with all new admissions to assist in the adjustment process. How the corrective action will be monitored: How often and for how long will this plan of correction be monitored? Behavior management/unnecessary drug CQI will be completed weekly times four weeks, monthly times three months and then quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. Social Services Director will be responsible for compliance. Will monitoring occur on all shifts? Monitoring will occur on day and evening shifts. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. **By what date the systemic changes will be completed:** August 20, 2011	

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	On 7/17/11 at 6:00 p.m., the resident was indicated as mildly to moderately anxious and was medicated per physician's orders. On 7/19/11 at 12:12 p.m., the resident was confused and forgetful and asked repetitive questions regarding his discharge. No information to assist the resident in coping/adjusting to his admission and also concerning the resident's anxiousness were indicated. On 7/19/11 at 7:50 a.m., Resident #59 was observed in the Moving Forward dining room awaiting breakfast. He was inquiring where he was, what he was doing her, and who were "all these people" as breakfast preparations were being completed. On 7/20/11 at 10:20 a.m., Resident #59 was observed in his wheelchair in the hallway by the nurse's station. He was heard to be asking where he was and who these people were in the hallway. On 7/21/11 at 8:45 a.m. during an interview, the Director of Nursing (DON) indicated the staff did stop and answer Resident #59's questions. On 7/21/11 at 9:50 a.m. during an interview, the Activity Director indicated			

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	the resident was asked to go to activities and was presently being evaluated concerning 1 to 1 visits. An activity care plan was presented with the identified problem was resident was reluctant to participate in group activities with his stated interest as in the past. At this same time during an interview, the DON indicated a physician order was received on 7/19/11 for psychiatric services to evaluate and treat the resident. On 7/21/11 at 12:50 p.m. during an interview, Social Services #16 indicated he did not have any information concerning Resident #59's anxiousness. 3.1-43(a)(1)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, record review, and interviews, the facility failed to ensure a personal body alarm was functional for 1 of 2 residents reviewed (Resident #61), who had a recent right hip fracture from a fall in the prevention of further falls and to ensure the right sized spoon was given to a resident at mealtime for 1 of 1 resident reviewed, who was at risk for choking, (Resident #18) in a sample of 15.	F0323	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does ensure that the resident environment is as free of accidents as possible and assistive devices are provided to prevent accidents. **Corrective**	08/20/2011

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	Findings include: 1. Resident #61's record was reviewed on 7/18/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to, open reduction internal fixation of the right hip, dementia, and debility. The resident was admitted to the facility on 7/01/11. The physician order, dated 7/01/11, was bed alarm and wheelchair alarm for safety. The "Event Report," dated 7/02/11, indicated the resident was found in her room lying on her left side next to her bed on this same day at 6:50 a.m. The resident indicated she was trying to go to the bathroom. The environmental factor was the resident was a new admission to the facility. The interventions indicated as "put into place to prevent another fall" were 15 minute checks, and the resident was sent to the hospital for X-rays. She returned to the facility with no apparent injury. The "Progress Note," dated 7/05/11 at 8:53 a.m., indicated in the IDT (Interdisciplinary Team) meeting concerning the resident's fall from her bed going to the bathroom, interventions were to place the resident on a bowel and bladder program, maintain her alarm to bed, and continue the current therapy with		**action accomplished for those residents found to have been affected** Regarding Resident #61, resident was re-assessed for fall risk and the care plan was updated with additional interventions. Regarding Resident #18, the ADNS removed the teaspoon and provided the resident with a small spoon. Speech Therapy will continue to work with this resident on eating techniques. **How the facility identified other residents having the potential to be affected:** All residents with personal alarms were immediately checked for appropriate placement and function, verified and then documented on the MAR/TAR. No other residents in the facility eat with a small (baby) spoon. **Systemic Changes the facility made:** On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator provided an inservice to nursing staff with post-test regarding: 1) Placement of alarm, utilization of CNA assignment sheets and what to do in the event that a device is not working or missing. 2) Checking meal tickets for appropriate assistive devices and communicating to the cook if an assistive device is missing prior to serving the meal. **How the corrective action will be monitored:** How often and for how long will this plan of	

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	therapy aware of the fall. The "Event Report," dated 7/06/11, indicated the resident was found in her room sitting on the floor with her legs straight out in front of her on this same day at 6:00 a.m. The resident had been incontinent of urine at this time. She also indicated she was attempting to go to the bathroom. The intervention to prevent another fall was 15 minute checks. The "Progress Note" in this report included, but was not limited to, the following: On 7/06/11 at 6:00 a.m., the alarm was indicated as "in place" with no information indicated if it was functional and/or alarming. The resident was assisted back to her bed as "no gross deformities observed." At 8:29 a.m. on this same day, the resident was complaining of pain to the right leg. After the physician was notified, a 1 time pain medication was given. At 10:14 a.m. on this same day, the resident was complaining of right upper leg pain with the limb indicated as appearing shorter and with external rotation with tenderness along the femur (leg bone). The physician was notified and the resident was sent to the emergency room for X-rays. On 7/14/11 at 9:45 a.m., the "Fall" IDT meeting indicated the resident had returned from the hospital after the fall. The resident was started on a 3 day bowel		correction be monitored? Resident rounds CQI tool will be completed daily (5 days per week) for two weeks, weekly times four weeks, monthly times three months and quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. DNS will be responsible for the coordination of this monitoring. How often and for how long will this plan of correction be monitored? Meal observation/preparation CQI tool will be completed daily (5 days per week) times two weeks at every meal, weekly times four weeks and then quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. Dietary Services Manager will be responsible for monitoring. **How often will the Quality Assurance Committee be involved in monitoring this plan of correction?** The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action.Will monitoring occur on all shifts? Monitoring will occur on all shifts. **By what date the systemic changes will be completed:** August 20, 2011	

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	and bladder pattern, and would continue the toileting program until the assessment was completed. The bed alarm, chair alarm, mat on the floor beside bed, the bed in the lowest position, and a lap buddy in the wheelchair were indicated as present interventions. At 4:54 p.m. on this same date and after discussing interventions with the family, the bed was to be placed against the wall and a mattress with small bolsters for perimeter reminders were added. Also, if the resident was not using the siderails, they would be reassessed and discontinued if not indicated. The right hip x-ray, dated 7/06/11, indicated the resident has a fracture through the femoral neck with a 90 degree varus angulation deformity. On 7/19/11 at 8:40 a.m., Resident #61's transfer was observed by CNA #11 and CNA #12. After hooking the Hoyer lift to the Hoyer sling, Resident #61 was lifted from her wheelchair and transferred to her bed. No personal body alarm (PBA) from the wheelchair was heard alarming during this transfer. At this same time during an interview, LPN #7 checked the alarm and found it to be in the "off" position. When the PBA was turned on, the alarm was heard.			

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	On 7/20/11 at 2:55 p.m. during an interview, LPN #13 indicated she was present on the day Resident #61 fell and fractured her hip. She indicated as she was receiving her report, she heard Resident #61 yell out. She indicated when she arrived at the room, the resident was found on the floor. She indicated the bed alarm was on the bed, but she only remembered the resident yelling out and not the alarm. 2. The record for Resident # 18 was reviewed on 7/18/11 at 5 p.m. Current diagnoses included, but were not limited to, aspiration syndrome, dysphagia, (difficulty swallowing) and history of choking. A physician order dated 7/14/11 indicated an order for a pureed diet with pudding thick liquids both via a small spoon. A speech therapy plan of treatment note dated 7/14/11 indicated the resident swallowed safely with less than 1/2 teaspoon (small spoon utilized) of pudding thick liquids and 1/4-1/2 teaspoon of pureed food. During observation of the lunch meal on 7/18/11 at 1:05 p.m.,the resident was assisted to eat his diet with a small (baby) type spoon.			

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	During the supper meal on 7/18/11 at 6:15 p.m., the resident received his tray. He reached his spoon and began feeding himself his pudding thick liquids. The spoon was a regular dining teaspoon. He continued to feed himself from his puree food. He would heap the teaspoon and take bites one after the other. The resident began coughing. At that time, the Assistant Director of Nursing ADON) was informed the resident was feeding himself with the wrong spoon. The ADON removed the teaspoon from the resident and a small (baby) type spoon was given to the resident. The ADON indicated at that time the resident always coughed when eating. 3.1-45(a)(2)			
F0328 SS=E	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review, observation, and interview, the facility failed to ensure oxygen and nebulizer treatments were administered in a manner to prevent	F0328	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's	08/20/2011

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	possible complications and oxygen was initiated by licensed personnel for 2 of 2 residents reviewed for oxygen administration (Resident # 18 and # 62) and failed to ensure PICC (Peripherally Inserted Central Catheter) was removed in a manner to prevent possible complication for 2 of 3 residents reviewed for PICC lines (Resident # 25 and # 60) in a sample of 15. Findings include: 1. The record for Resident # 18 was reviewed on 7/18/11 at 5 p.m. Current physician orders for July 2011 indicated an order for oxygen to be administered via a nasal canula to keep oxygen saturations greater than 90 %, no liter flow rate was indicated. The July Treatment Administration Record (TAR) for July 2011 lacked oxygen saturation levels. The TAR indicated the oxygen was set at 2 liters During a transfer observation on 7/18/11 at 11:30 a.m., Resident # 18 was transferred to his wheelchair. CNA # 8 placed the resident's oxygen tubing on the portable oxygen tank and turned the liter flow to 2 liters. At that time, during interview, CNA # 8 indicated as a CNA		desire to comply with the regulatory requirements and to continue to provide quality care. The facility does ensure that residents receive proper treatment and care for specialized services. **Corrective action accomplished for those residents found to have been affected** Regarding Resident #18, oxygen orders were clarified to indicate liter flow. Regarding Resident #60, the PICC line was removed and was documented that the PICC line was intact. Regarding resident #62, nebulizer cup was rinsed. **How the facility identified other residents having the potential to be affected:** Any resident with a PICC line in the past 30 days were reviewed and no residents were negatively affected. Any resident on oxygen or nebulizer has the potential to be affected. **Systemic Changes the facility made:** On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator provided nursing staff with an in-service with post-test regarding administration of nebulizer treatments to include rinsing the nebulizer before and after the treatment. On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator provided nursing staff with an in-service with post-test regarding oxygen therapy and only nurses will set the liter flow of oxygen.	

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	she was able to set the liter flow rate of oxygen. During interview on 7/20/11 at 11:20 a.m., the Director of Nursing indicated only licensed nurses should set the flow rate of oxygen. 2. During a nebulizer treatment observation with LPN # 1 on 7/18/11 at 11 a.m., LPN # 1 finished administering the nebulizer treatment to Resident # 62. He then placed the mask and the medication container in a plastic bag on the resident's nightstand. He did not rinse the cup before or after the treatment. A 1/2010 policy titled "Nebulizer Treatment" was provided by the Director of Nursing on 7/20/11 at 8:25 a.m., and deemed as current. The policy indicated: "...Procedure...Charge nurse will stay with resident while treatment is being delivered. 15. Rinse equipment and place back in plastic storage bag...." 3. The record for resident # 25 was reviewed on 7/19/11 at 8:20 a.m. A physician order dated 5/4/11 indicated an order to discontinue the PICC line. The progress notes and TAR for 5/4/11 lacked documentation of the removal with		All residents with oxygen orders will be reviewed for completeness. On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator provided nursing staff with an in-service on PICC lines to include documentation of removal and obtaining catheter length. How the corrective action will be monitored: All nurses will be re-educated on PICC line removal. All newly hired nurses will be educated on PICC line removal during orientation. All nurses will be provided with refresher PICC line removal education ongoing as residents receive a PICC line. How often and for how long will this plan of correction be monitored? Oxygen therapy CQI will be completed weekly times four weeks and quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. DNS will be responsible for monitoring. Will the DNS monitor oxygen therapy on all shifts? DNS/Designee will monitor oxygen therapy on all shifts.	

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	measurement of the catheter and the intactness of the tip. On 7/20/11 at 11:20 a.m., additional information was requested from the Director of Nursing regarding the assessment of the PICC line after removal. On 7/20/11 at 4:15 p.m., the Director of Nursing indicated the nurse who had removed the PICC line had not documented at the time, but wrote a statement today that indicated the tip was intact. She indicated there was no measurement of the catheter. 4. The record for Resident # 60 was reviewed on 7/20/11 at 1:50 p.m. A physician order dated 7/13/11 indicated an order to discontinue the PICC line on 7/14/11. A progress note dated 7/14/11 at 7:10 p.m., indicated the PICC line was removed and the tip was intact. No measurements of the catheter was documented. Additional information was requested from the Director of Nursing on 7/20/11 at 3:05 p.m., regarding the measurement of the catheter.		How often and for how long will this plan of correction be monitored? Infection control CQI audit will be completed daily times two weeks (5 days per week), weekly times four weeks and then quarterly thereafter for at least 6 months and if at any time following this, issues are identified; the IDT will review and determine if further action is necessary. DNS will be responsible for compliance. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. Will monitoring occur on all shifts? Monitoring will occur on all shifts. **By what date the systemic changes will be completed:** August 20, 2011	

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	No additional information was provided by the time of the final exit on 7/21/11. A policy dated August 15, 2008, titled "Peripherally Inserted Central Catheter (PICC) Removal" was provided by the Administrator on 7/20/11 at 8:25 a.m., and deemed as current. The policy indicated: "...Considerations 1. The nurse must be aware of the catheter length prior to removal...Procedure...23. Measure catheter length and assess catheter tip to ensure that entire catheter was removed...." 3.1-47(a)(2) 3.1-47(a)(6)			

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	155066	A. BUILDING 00 B. WING	07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER WOODS	1809 N MADISON AVE ANDERSON, IN46011

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observations, interviews, and record review, the facility failed to ensure a resident was assessed and evaluated for non-medical interventions related to his anxiety prior to administration of an anti-anxiety medication for 1 of 1 resident reviewed for anxiety in a sample of 15. (Resident #59) Findings include: 1. Resident #59's record was reviewed on 7/18/11 at 4:40 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease.	F0329	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does ensure that each resident's drug regimen is free of unnecessary drugs. **Corrective action accomplished for those residents found to have been affected** Regarding Resident #59, the physician was contacted and an order was received for a psychiatric evaluation and treatment for the resident. **How the facility identified other residents having the potential**	08/20/2011

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	The undated "Social History & Psychosocial Assessment" indicated the resident was admitted on 7/02/11. The "Cognitive/Emotional Status/How does the resident cope?" indicated the resident was confused and anxious. The "Event(s) Leading to Placement and Reason(s) for Admission" was indicated as increased confusion. The "Mood or behavior's noted" was indicated as the resident was anxious. The physician order, dated 7/02/11, was Lorazepam (Ativan) (anti-anxiety) 0.5 milligrams give 1 tables 3 times a day as needed. The "MEDICATION ADMINISTRATION RECORD (MAR)" for 7/2011 indicated the following: Lorazepam (Ativan) 0.5 milligrams was indicated as given in this order on the back of the MAR as follows: On 7/06 at 4 p.m.; on 7/07 at 4 p.m.; on 7/09 at 6: (unclear) p.m.; on 7/10 at 2:15 p.m.; on 7/12 at 2:(unclear); on 7/15 at 7:50 p.m.; on 7/16 at 6 p.m.; on 7/04 at 5 p.m.; on 7/06 at 5 p.m.; on 7/11 at 6 p.m.; on 7/14 at 7 p.m.; on 7/17 at 6 p.m.; and on 7/18 at 11:15 a.m. The reason listed for all of the above medication administration was "anxiety." The results were all indicated as effective.		**to be affected:** All newly admitted residents will be reviewed for difficulties in adjustment. Any issues identified will be communicated to the attending physician. **Systemic Changes the facility made:** On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Social Services provided an in-service for all staff members with post-test on behavior management. Any residents identified with symptoms of difficulty adjusting, the staff will complete a behavior form and communicate to the charge nurse and social services. A care plan will be developed with interventions to address the behavior. This will be communicated to the staff via the CNA assignment sheet and care plan. Any new or worsening behaviors will be reviewed by the IDT and care plan will be revised as indicated. Social Services will work with all new admissions to assist in the adjustment process. On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator provided Licensed nurses an inservice with post-test on documentation of PRN psychotropic medications and non-medical interventions will be provided prior to administration of psychotropic medications. Pharmacy consultant will conduct a full-house audit to determine all drugs are necessary. How the corrective action will be monitored:	

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	The "Resident Progress Notes" indicated the following: On 7/02/11 at 4:00 p.m., the resident was admitted to the facility. He was indicated as alert and confused, moderately anxious at times, and is forgetful. On 7/04/11 at 11:21 a.m., the resident was restless and agitated. He was continuously asking to go home and leave. The resident stated he was left here and was being held. The resident was redirected numerous times which were unsuccessful, and Ativan (anti-anxiety) medication was given. The resident did calm down. On 7/05/11 at 11:40 p.m., the resident was indicated as alert but very confused, and "anxious at times," with Ativan given at 6:00 p.m. "with some relief." On 7/10/11 at 2:15 p.m., the resident was sitting in the hallway looking around and interacting with staff with no further complaints. He was medicated for anxiety. On 7/17/11 at 6:00 p.m., the resident was indicated as mildly to moderately anxious and was medicated per physician's orders. No further information was indicated regarding the use of non-medical interventions prior to the medication administration of Lorazepam (Ativan).		How often and for how long will this plan of correction be monitored? Behavior management/unnecessary drug CQI will be completed weekly times four weeks, monthly times three months and then quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. Social Services Director will be responsible for compliance. Will monitoring occur on all shifts? Monitoring will occur on day and evening shifts. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. **By what date the systemic changes will be completed:** August 20, 2011	

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	On 7/19/11 at 7:50 a.m., Resident #59 was observed in the Moving Forward dining room awaiting breakfast. He was inquiring where he was, what he was doing her, and who were "all these people" as breakfast preparations were being completed. On 7/20/11 at 10:20 a.m., Resident #59 was observed in his wheelchair in the hallway by the nurse's station. He was heard to be asking where he was and who these people were in the hallway. On 7/21/11 at 8:45 a.m. during an interview, the Director of Nursing (DON) indicated the staff did stop and answer Resident #59's questions. On 7/21/11 at 9:50 a.m., the Activity Director indicated the resident was asked to go to activities and was presently being evaluated concerning 1 to 1 visits. At this same time during an interview, the DON indicated a physician order was received on 7/19/11 for psychiatric services to evaluate and treat the resident. 3.1-48(b)(1) 3.1-48(b)(2)			

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F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure pureed menus were followed for 2 of 2 residents reviewed for pureed diets in a sample of 15 (Residents #46 & #53) and 2 of 2 residents reviewed for following pureed menus in a supplemental sample of 6 (Residents #52 and #37). This deficient practice had the potential to impact the 19 residents with physician's orders for pureed diets. Findings include: 1.) Resident #52's record was reviewed on 7/20/22 at 10:15 a.m. Resident #52's current diagnoses included, but were not limited to, Huntington's chorea, speech disorder, and dysphasia. Resident #52 had a current, 4/1/11, physician's order for a pureed diet. 2.) Resident #46's record was reviewed on 7/18/11 at 10:50 a.m. Resident #46's current diagnoses included, but were not limited to, mental	F0363	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does provide menus that meet the nutritional needs of the residents. **Corrective action accomplished for those residents found to have been affected** Regarding Residents 52, 46, 37 and 53, the residents were served two ounces of pureed cottage cheese and one extra portion of bread sticks to correct the serving size. **How the facility identified other residents having the potential to be affected:** All residents on a pureed diet had the potential to be affected and were provided the cottage cheese and breadsticks to correct the serving. **Systemic Changes the facility made:** On 8/15/11, the Registered Dietician will re-inservice Dietary staff with return-demonstration on portion sizes during meals and preparation of pureed food. All new dietary staff will be educated on portion sizes and preparation	08/20/2011

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	retardation, speech disorder, and depression. Resident #46 had a current, 1/10/11, physician's order for a pureed diet. 3.) Resident #37's record was reviewed on 7/20/11 at 9:15 a.m. Resident #37's current diagnoses included, but were not limited to, mental retardation, mental retardation, and depression. Resident #37 had a current, 7/22/10, physician's order for a pureed diet. 4.) Resident #53's record was reviewed on 7/18/11 at 10:45 a.m. Resident #53's current diagnoses included, but were not limited to, mental retardation, legally blind and dysphasia. Resident #53 had a current, 12/14/10, physician's order for a pureed diet. 5.) Review of a menu/spreadsheet for 4/19/11, breakfast, which was provided by the Food Services Supervisor on 7/18/11 at 9:45 a.m., indicated residents with pureed diets were menued to receive 3/8 cup (3-4 ounces) pureed sausage gravy and 5 and 1/3 tablespoon (3 ounces)of		of mechanically altered diets. Dietary manager will oversee the tray line to ensure portion sizes are accurate. How the corrective action will be monitored: How often and for how long will this plan of correction be monitored? Meal observation/preparation CQI tool will be completed daily (5 days per week) times two weeks at every meal, weekly times four weeks and then quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. Dietary Services Manager will be responsible for monitoring. Will the Dietary Services Manager monitor all three meals? Dietary Services Manager/Designee will monitor all three meals. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. Will monitoring occur on all shifts? Monitoring will occur with all three meals. **By what date the systemic changes will be completed:** August 20, 2011	

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	pureed biscuits. 6.) During a 7/19/11, 8:05 a.m. to 8:20 a.m., breakfast observation, Residents #52, #46, #37 and #53 were served a 1/3 cup (2.7 ounce) portion of pureed sausage gravy and biscuits which were mixed together. This portion was smaller than the menued amount. During a 7/19/11, 8:20 a.m. interview Cook #14 indicated he had prepared the pureed sausage gravy and biscuits together and was serving a #12 scoop/ 1/3 cup portion of the mixed food product. During a 7/19/11, 8:21 a.m., interview the Food Services Supervisor indicated the portion of pureed sausage gravy and biscuits was a portion size error and too small a serving. She indicated the error would be addressed by serving additional items at a later meal. During a 7/19/10, 12:40 p.m., interview, the Food Services Supervisor indicated the error from the pureed sausage at breakfast would be corrected by serving 2 ounces of pureed cottage cheese and 1 extra portion of breadsticks during the lunch meal. 7.) Review of an undated, form titled "Number of Residents by Diet", which			

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	was provided by the Administrator on 7/19/11 at 10:55 a.m., indicated 19 current residents had physician's orders for a pureed diet. 3.1-20(i)(1) 3.1-20(i)(4)			
F0365 SS=E	Each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure residents who had physician's orders for a mechanical soft diet, were served food in a mechanical soft form for 1 of 1 resident in a sample of 15 reviewed for mechanical soft diets as ordered (Resident #42) and 3 of 3 residents in a supplemental sample of 6 reviewed for mechanical soft diets as ordered (Residents #51, #48 and #38). This deficient practice had the potential to impact the 10 residents who had physician's orders for a mechanical soft diet. Findings include: Review of the current, facility, menu/spreadsheet for the 7/18/11 lunch, which was provided by the food services supervisor on 7/19/11 at 9:45 a.m., indicated resident's with orders for a	F0365	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does provide food prepared in a form designed for the individual needs of residents. **Corrective action accomplished for those residents found to have been affected** Regarding Residents 42, 51, 48, 38, the lettuce and tomato were removed from the tray prior to consumption. **How the facility identified other residents having the potential to be affected:** All other mechanical soft diet trays were checked and lettuce and tomato were removed and replaced with tomato juice per menu. **Systemic Changes the facility made:** On 8/15/11, the Registered Dietician will re-inservice Dietary staff with	08/20/2011

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	mechanical soft diet could not have fresh tomatoes and lettuce and were menued to have tomato juice in it's place. 1.) Resident #42's record was reviewed on 7/18/11 at 11:00 a.m. Resident #42's current diagnoses included, but were not limited to, history of head injury, mental retardation and hypertension. Resident #42 had a current 7/11 physician's order, which originated 8/27/10, for a mechanical soft diet. Resident #42 had a current 4/21/11, quarterly, Minimum Data Set Assessment, which indicated he needed a mechanically altered diet. Resident #42 had a current 11/23/10 care plan problem/need regarding a risk for chocking. An approach to this problem was to serve the diet as ordered. 2.) Resident #51's record was reviewed on 7/20/11 at 10:00 a.m. Resident #51's current diagnoses included, but were not limited to, depression, mental retardation and speech disorder. Resident #51 had a current, 2/2/11,		return-demonstration on serving and preparation of specialty diets. On 8/2/11, 8/5/11, 8/8/11 and 8/12/11, Staff Development Coordinator in-serviced nursing staff with post-test on serving meals to ensure appropriate diet. The Dietary manager will oversee the tray line to ensure diet consistencies are accurate. How the corrective action will be monitored: How often and for how long will this plan of correction be monitored? Meal observation/preparation CQI tool will be completed daily (5 days per week) times two weeks at every meal, weekly times four weeks and then quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. Dietary Services Manager will be responsible for monitoring. Will the Dietary Services Manager monitor all three meals? Dietary Services Manager/Designee will monitor all three meals. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. Will monitoring occur on all shifts? Monitoring will occur	

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	physician's order for a mechanical soft diet. Resident #51 had a current 5/4/11, quarterly, Minimum Data Set Assessment, which indicated she required a mechanically altered diet. Resident #51 had a current, 2/16/11, problem/need regarding a potential for aspiration. An approach to this problem was to serve the diet as ordered. 3.) Resident #48's record was reviewed on 7/20/11 at 9:45 a.m. Resident #48's current diagnoses included, but were not limited to,mental retardation, anxiety, and hypertension. Resident #48 had a current, 2/8/11, physician's order for a mechanical soft diet. Resident #48 had a current, 5/5/11, quarterly, Minimum Data Set Assessment, which indicated the resident required a mechanically altered diet. 4.) Resident #38's record was reviewed on 7/20/11 at 9:30 a.m. Resident #38's current diagnoses included, but were not limited to, mild mental		with all three meals. **By what date the systemic changes will be completed:** August 20, 2011	

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	retardation and cerebral palsy. Resident #38 had a current, 11/1/10, physician's order for a mechanical soft diet. Resident #38 had a current, 11/24/10 care plan problem regarding a risk for chocking. An approach to this problem was to serve a diet as ordered. 5.) During a 7/18/11, 12:18 p.m. to 12:50 p.m., lunch meal observation, Residents #42, #51, #48 and #38, who had physician's orders for a mechanical soft diet as indicated above, were all served fresh tomatoes and lettuce. During a 7/18/11, 12:50 p.m., interview the Food Services Supervisor indicated residents with mechanical soft diets should not receive fresh tomatoes and lettuce and those items had been served in error. Review of an undated, form titled "Number of Residents by Diet", which was provided by the Administrator on 7/19/11 at 10:55 a.m., indicated 10 current residents had physician's orders for a mechanical soft diet. 3.1-21(a)(3)			

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F0425 SS=E	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, observation, and interview, the facility failed to ensure pharmacy services were provided to ensure a new physician order was communicated to the facility for 1 of 15 residents reviewed for new orders (Resident # 25) and failed to ensure medications were available for administration for 4 of 4 residents reviewed for medication availability in a sample of 15. (Resident # 25, # 28, # 22 and # 57) Findings include: 1. The record for Resident # 25 was reviewed on 7/19/11 at 8:20 a.m.	F0425	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and to continue to provide quality care. The facility does provide routine and emergency drugs to the residents as ordered by the physician. **Corrective action accomplished for those residents found to have been affected** Regarding Residents 25, 28, 22 and 57, all medications were located or provided for the residents. **How the facility identified other residents having the potential to be**	08/20/2011

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	During a medication pass observation with LPN # 1, on 7/19/11 at 9:45 a.m., the resident was administered an oxycodone 5 milligram tab. During reconciliation of the medication pass, the physician order on the July orders was for oxycodone 5 milligrams 2 tabs as needed every 2 hours for pain. The original date of this order was 6/4/11. At 11 a.m., the Director of Nursing was queried regarding the order for the oxycodone. At that time during interview, she indicated the physician had sent a script directly to the pharmacy for the oxycodone 5 milligrams 2 tabs without notifying the facility. During interview on 7/19/11 at 12:45 p.m., the Director of Nursing indicated the pharmacy had failed to notify the facility of the medication change. The July Medication Administration Record (MAR) reflected the order for 5 milligrams 2 tabs. The back of the July MAR indicated the resident received one tab on 7/6/11 at 6 a.m., 7/12/11 at 12:30 p.m., and 7/19/11 at 9:45 a.m.. Current physician orders for July 2011 indicated an order for Lyrica 150 milligrams to be given twice daily. The MAR for July 2011 indicated the Lyrica was unavailable on 7/7/11-7/9/11, for 6 doses.		**affected:** A medication cart audit was completed and any medications needed were located or ordered. **Systemic Changes the facility made:** Pharmacy will provide an in-service on 8/16/11 for nurses on the importance of signing off on medications that are administered. Any medications that are unavailable will be obtained from the EDK if possible. The pharmacy will be contacted for a stat delivery and the physician will be notified. How the corrective action will be monitored: How often and for how long will this plan of correction be monitored? Facility will complete an audit at least quarterly to review carts for availability of medications. Pharmacy will complete a quality assurance visit to review carts for availability of medications. Discrepancies will be reported to the DNS. This plan of correction will be monitored for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. The DNS/Designee will be responsible to monitor. Will monitoring occur on all shifts? Monitoring will occur on all	

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	A FAX document was provided by the Administrator on 7/21/11 at 11 a.m. The document indicated the Lyrica had been ordered on 7/5/11 and 7/8/11. The Lyrica arrived on 7/9/11. 2. The record for Resident # 28 was reviewed on 7/20/11 at 10:40 a.m. Current physician orders for July 2011 indicated an order for Allegra 180 milligrams daily. Original date of the order was 2/10/11. The June 2011 MAR indicated the Allegra was unavailable on 6/20/11 and 6/21/11. During interview on 7/21/11 at 9:50 a.m., the Director of Nursing indicated the resident had missed 2 doses of the Allegra. 3. The record for Resident # 22 was reviewed on 7/18/11 at 2:30 p.m. Physician orders for July 2011 indicated an order for Vitamin D 50,000 units to be given weekly. Original date of the order was 10/27/10. The May 2011 MAR indicated the Vitamin D was unavailable for administration on 5/2/11, 5/16/11 and		shifts. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. **By what date the systemic changes will be completed:** August 20, 2011	

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	5/30/11. During interview on 7/21/11 at 9:50 a.m., the Director of Nursing indicated the Vitamin D had to be re-ordered each month and had not been ordered. 4. Resident #57's record was reviewed on 7/18/11 at 5:20 p.m. The resident's diagnoses included, but were not limited to, hyperlipidemia. The physician's order, originally dated 6/24/11 and signed 7/13/11, was Simvastatin 20 milligram 1 tablet orally at bedtime for hyperlipidemia. The "MEDICATION ADMINISTRATION RECORD" for 7/2011 indicated the medication, Simvastatin was unavailable for administration on 7/03, 7/04, 7/06, 7/07, 7/08, 7/09, and 7/10/11. On 7/21/11 at 12:55 p.m. during an interview, the Director of Nursing indicated the pharmacy reportedly had sent her an authorization form to be filled out for Resident #57's medication, Simvastatin, when the order was received. She also indicated she did not receive this authorization form until 7/09/11 when only 4 pills of the medication were received.			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observations, interview, and record review, the facility failed to ensure infection control practices were followed in a manner to prevent the potential for the spread of infections and diseases	F0441	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the	08/20/2011

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	concerning handwashing and glove use for 4 of 5 CNAs (CNA#s 4, 5, 11, and 12) observed for 1 of 2 residents (Resident #61) during personal care/transfers, concerning meal trays being passed for 3 of 8 residents (Resident #'s 59, 61, and 63) observed for 5 of 7 staff members (RN #6, LPN #1, Physical Therapist #9, and CNA #'s 4 and 10), concerning linen handling for 1 of 1 laundry aide (Laundry Aide #15) for 1 of 1 observation in the laundry, and concerning medication pass for 2 of 7 nursing staff (LPN #1 and RN #3) for 3 of 13 residents (Resident #'s 28, 60, and 25) observed during medication pass, and concerning a dressing change for 1 of 1 resident (Resident #18) observed for 1 of 1 dressing change observed. Findings include: 1. On 7/18/11 from 11:05 a.m. to 11:40 a.m., Resident #61's transfer and personal care was observed. Upon entering CNA #4 was observed to handwash for less than 15 seconds and donned a pair of gloves. CNA #4 and CNA #5 hooked the Hoyer lift to the Hoyer sling the resident was sitting on in the wheelchair. Next, as CNA #4 attempted to operate the Hoyer lift without success, she indicated the battery was dead. CNA #5 removed her gloves, left the room with no		regulatory requirements and to continue to provide quality care. The facility does establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment. **Corrective action accomplished for those residents found to have been affected:** Residents #61 and #65 were not affected. CNA #4 and CNA #5 were re-inserviced on hand washing. Regarding RN #6, there was no resident or food contact cited. RN #6 was re-inserviced on hand washing. Regarding resident #59, LPN #7 was re-inserviced on hand washing and tray/meal service. Regarding resident #63, CNA was re-inserviced on hand washing. LPN #10, LPN #1, Laundry Aide #15, CNA #10, CNA #11, CNA #12 and PT #9 were re-inserviced on hand washing. RN#3 was re-inserviced on medication set up. Resident #60 was not affected. Regarding resident #25, an assessment of the resident's eye was completed and there are no symptoms of infection. **How the facility identified other residents having the potential to be affected:** An infection surveillance report was completed to identify trends and clusters of infections and there were no issues identified. **Systemic Changes the facility made:** On 8/2/11, 8/5/11, 8/8/11	

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	handwashing/handgel use, and returned with a new battery for the Hoyer lift. Resident #61 was then transferred from her wheelchair to the bed. After the resident's personal care was completed, with the same gloves CNA #4 checked both of her uniform pockets and retrieved a plastic bag and bagged the brief. With the same gloves the resident's bed was repositioned up against the wall, then, CNA #4 removed her gloves and with the bed remote elevated the resident's head of bed before she was observed to handwash. At this same time during an interview, CNA #4 indicated one should handwash for 20 seconds and before and after resident care. 2. On 7/18/11 from 12:15 p.m. to 1:00 p.m., lunch was observed in the Moving Forward dining room. The following was observed: RN #6 was observed to handwash, turn the water off with her wet hand, and then, dried her hands. She was then observed to obtain the milk pitcher as drinks were being prepared. After passing several meal trays, RN #6 was again observed to handwash, turn the water off with her wet hand, and then, dried her hands. She then proceeded to obtain a straw for Resident #61 as she was observed to use the straw in her orange drink.		and 8/12/11, Staff Development Coordinator provided facility staff an in-service with post-test and return demonstration regarding hand washing and glove usage pertaining to meal service, administration of medications and dressing changes. Skills validations for hand washing, glove usage, medication administration and dressing changes will be completed on all licensed nurses by 8/20/11. Any resident identified with a potential infection will have a surveillance investigation completed. All nosocomial infections will be investigated for trends, an infection rate will be determined, and a plan will be developed to address the trends for any issues identified. How the corrective action will be monitored: How often and for how long will this plan of correction be monitored? An infection control CQI will be completed daily (5 days per week) for two weeks, weekly times four weeks and then quarterly thereafter for at least 6 months and if at any time following this, issues are identified, the IDT will review and determine if further action is necessary. An infection surveillance report will be completed monthly and evaluated for any clusters or trends.	

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	LPN #7 was observed to cut Resident #59's egg salad sandwich in half. With the egg salad observed on her hands, LPN #7 was observed to wet her hands and dry them as she left the dining room. Resident #59 was observed to be eating his egg salad sandwich. CNA #4 was observed to pick up soiled dishes, handwashed for less than 15 seconds, and then, serve Resident #63 his substitution for the meal removing the lid. 3. On 7/18/11 from 5:25 p.m. to 6:05 p.m., dinner was observed in the Moving Forward dining room. As staff entered to assist with passing meal trays, LPN #7 was observed to handwash, turn the water off with her wet hands, and then dried her hands. Also, Physical Therapist #9 was observed to handwash for less than 20 seconds as she passed meal trays. CNA #10 was observed to handwash for less than 15 seconds as she was observed to pass the drinks/meal trays. 4. On 7/19/11 at 8:40 a.m., Resident #61's transfer from her wheelchair to her bed for a change of clothes were observed. After the transfer and change in clothing had been completed, CNA #11 was observed to leave the room, obtain a lap cover from the linen closet on this		The DNS/Designee will be responsible for the coordination of monitoring and compliance. Will the infection control CQI/DNS monitoring occur on all shifts? The infection control CQI/DNS/Designee will monitor on all shifts. How often will the Quality Assurance Committee be involved in monitoring this plan of correction? The Quality Assurance Committee (CQI Committee) will meet at least monthly to review the trends of auditing and staff skills validations and make recommendations for further staff development and/or action. **By what date the systemic changes will be completed:** August 20, 2011	

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	hallway, and return to the resident's room where the lap cover was put over the resident's legs. Next, CNA #11 entered Resident #65's room to check on him. 5. On 7/19/11 from 9:10 a.m. to 9:50 a.m., Resident #61's personal care was observed. a.) Resident #61 had been incontinent of urine and a large amount of dark brown liquid stool. As CNA #12 with gloved hands did the resident's front peri-care, brown BM (bowel movement) was observed on the washcloth with each wipe and also a small amount on her gloved hand. CNA #12 removed her gloves and donned a new pair of gloves. No handwashing/handgel use was observed. CNA #12 completed cleaning around the front peri-area. After the resident was turned and as the rectal area was being cleansed, an open area on the resident's buttocks was observed. CNA #12 removed her gloves and left the room. No handwashing/handgel use was observed. When CNA #12 returned to the room, she was observed to handwash for 15 seconds as she returned to the personal care, which was stopped as the resident was continuing to have liquid BM. b.) As CNA #11 and CNA #12 with gloved hands completed the personal care			

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	on Resident #61, CNA #11 removed the towel with incontinent liquid BM observed on it from in front of the abductor pillow and bagged it. CNA #11 cleansed the rectal area of incontinent BM, changed gloves with no handwashing/handgel use observed, and completed the cleansing of the rectal area. Both CNAs with the same gloves proceeded to reposition the resident in her bed putting a pillow under her head before they removed their gloves and handwashed. At this same time during an interview, CNA #11 indicated one should handwash for 20 seconds. She also indicated one should handwash after cleansing a resident during personal care and before and after any care with a resident. 6. On 7/19/11 from 1:15 p.m. to 2:50 p.m., the environmental tour was conducted. In the laundry room, Laundry Aide #15 with gloved hands was observed at the large sink running water over a sink of soiled linen containing fecal material. No protective covering was observed over her uniform. An apron with a plastic-like covering was observed folded on a shelf in the laundry room. Laundry Aide #15 was observed with the same gloves to turn the water off, take a paper towel and wiped her face of perspiration, removed her gloves and obtained another paper			

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	towel and again wiped her face off before she was instructed to wash her hands. She then proceeded to wash her hands. At this same time during an interview, she indicated she did not wear a protective covering while she worked between the soiled and clean linen. Also, at this same time during an interview, the Housekeeping Supervisor agreed a barrier should be worn between the clean and soiled linen. 7. During a medication pass observation 7/18/11 at 11:45 a.m., with LPN # 1, the LPN entered Resident # 28's room. He pushed up the resident's sleeve and injected insulin without wearing gloves. After the injection the LPN exited the room without washing his hands and went to the medication cart, documented in the medication book and placed his ink pen in his pocket. 8. During a medication pass observation on 7/18/11 at 4:45 p.m., with RN # 3, the RN, while setting up medication for Resident # 60, popped the Coumadin 2 milligrams into his hand, then placed it into the medication cup. The RN then administered the medication to Resident # 60. 9. During a medication pass observation on 7/19/11 at 9 a.m., with LPN # 1, LPN # 1 placed Resident # 25's eye drop bottle			

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	into his shirt uniform pocket. He then washed his hands and went the Resident at the dining room table and removed the eye drop bottle from his pocket and administered the eye drops without donning gloves. He used his ungloved hand to hold the eyes open for the instillation of the drops. He then placed the eye drop bottle in his uniform pocket and then placed them back in the medication cart. 10. The record for Resident # 18 was reviewed on 7/18/11 at 5 p.m. Current July orders indicated an order to clean the open area on the right inner ankle with carraklenz spray prior to treatment. During a wound care observation on 7/19/11 at 10:50 a.m., LPN # 1 removed the soiled dressing from Resident # 18's ankle. After washing his hand and donning new gloves, LPN # 1 applied the prescribed dressing. He did not clean the wound prior to applying the clean dressing. During interview at the end of the dressing change, LPN # 1 indicated he realized he had failed to clean the wound and would re-do the dressing change. 11. Policies dated July 2008 and titled "Laundry", and "Linen and Laundry", was			

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	provided by the Administrator on 7/20/11 at 8:25 a.m., and deemed as current. The "Laundry" policy indicated "...ALL laundry is considered contaminated. 2. Handle soiled linen, clothing on the nursing unit with a minimum of agitation/shaking...c. Laundry staff wear utility gloves or disposable gloves and aprons when sorting ALL linen for loading into washers. Gloves and apron are removed, and hands are washed before clean linen is removed from the washer for transfer to the dryer...." The "Linen and Laundry" policy indicated: "...Personnel handle, store, process and transport linen so as to prevent the spread of infection...4. Soiled linen...Containers are labeled, lined, plastic carts/bins with covers or well-fitted lids..." Policies dated 1/2010 and titled "Medication Administration", "Injection-Subcutaneous Procedure", "Eye Drop(s) Procedure", and " Dressing Change Policy and Procedure" was provided by the Administrator on 7/20/11 at 8:25 a.m., and deemed as current. The "Medication Administration" policy indicated "...3. Medications will be opened without contaminating...." The "Injection-Subcutaneous Procedure" indicated: "...3. Prepare medication...4. Don gloves. 5. Select site for administration...." The "Eye Drop(s)			

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	Procedure" indicated: "...2. Wash hands and don gloves...." The "Dressing Change Policy and Procedure" indicated: "...10. Cleanse wound according to physician order...." A policy dated 1/2010 and titled "Hand Washing Policy and Procedure" and a 2/2010 policy titled "Gloves" was provided by the Administrator on 7/20/11 at 8:25 a.m., and deemed as current. The "Hand Washing Policy and Procedure" indicated: "A. Purpose 1. To prevent the spread of infectious disease...3. When washing hands with soap and water, wet hands first with water, apply soap and rub hands together vigorously for at least 20 seconds...covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet...Decontaminate hands before and after having direct contact with patients including intact skin...4. Decontaminate hands before donning gloves...this includes changing of gloves in the middle of any procedure...5. Decontaminate hands if moving form a contaminated-body site to a clean body site during patient care...." The "Peri-Care" policy was provided by the Administrator on 7/20/11 at 8:25 a.m. This current policy indicated the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWATER WOODS	1809 N MADISON AVE ANDERSON, IN46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following: "A. Purpose 1. To cleanse the perineum for prevention of infection, irritation and to contribute to the resident's positive self-image ...C. Procedure ...7. Remove disposable brief or pad 8. Wipe off excess feces with toilet paper or clean area of brief or pad ...10. Place brief or pad in plastic bag 11. remove soiled gloves and wash hands ...18. Place soiled wash cloth in bag 19. Remove gloves and wash hands 20. Apply appropriate brief product and/or clothing 21. Make resident comfortable...." 3.1-18(l) 3.1-19(g)(1)			